

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**LOVENOX** (enoxaparin sodium)

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Ext. and options \_\_\_\_\_ Fax # \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**TELEPHONE AUTHORIZATION:**

**CRITERIA:**

- ▶ PRE-OPERATIVE for 3 days only for patients who must stop coumadin prior to surgery.
- ▶ POST- OPERATIVE for patients to be regulated on coumadin for 5 days only.
- ▶ POST operative prevention of DVT in patients with below and including abdomen surgeries, (i.e., hip, Acute knee, & ankle, not including foot and toes. (Max. 10 days).
- ▶ DVT/PE treatment in conjunction with coumadin regulation and treatment. (Max. 10 days)
- ▶ Unstable Angina: ischemic complications in unstable angina and non-Q-wave MI patients on concurrent aspirin therapy. (Max. 10 days)
- ▶ Prophylaxis or treatment of active DVT/PE in pregnancy.

**RE-AUTHORIZATION:**

Based on INR. Considered on an individual basis.

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**CRITERIA FOR PREGNANCY:**

**DOCUMENTATION FROM PROGRESS NOTES WITH ONE OF THE FOLLOWING DIAGNOSIS:**

- ▶ Past history of DVT/PE, **or**
- ▶ Active DVT/PE, **or**
- ▶ Known hypercoagulability

